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Strengthening the Foundations: Modernizing the Canada Health Act

by

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The views expressed herein are solely those of the authors and do not necessarily reflect those of the Commission on the Future of Health Care in Canada.

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Highlights

- The *Canada Health Act* (CHA) has served Canadians extremely well but needs to be updated to serve the needs of Canadians into the 21st century.

- The CHA should maintain the prohibitions on extra-billing and user charges. These are the key mechanisms ensuring equity in Medicare. There is no evidence that a greater role for private *financing* would improve either efficiency or equity in Medicare.

- The CHA appropriately prevents experimentation with private financing but neither impedes nor encourages reform or innovation in the *delivery* of health care. We think the CHA should be reformed to actively encourage innovation and evidence-based reform in the delivery of care.

- Universality is a fundamental principle, and should be maintained.

- The criterion of non-profit public administration should be amended to "public governance and democratic accountability" to emphasize the importance of good governance and accountability of decision makers at all levels in Medicare.

- The federal government should monitor the growth of health care delivery by for-profit firms but acknowledge that the CHA does not presently preclude their participation, ***provided services are fully publicly funded.***

- The CHA should require provinces to establish transparent and democratic processes to determine on an ongoing basis which services and goods should be publicly funded.

- If Medicare does not respond to Canadians' concerns regarding timeliness of treatment, support for it will be undermined and pressure for privately financed options will increase. The CHA should be amended to include a guarantee of timely access to meet Canadians' concerns about waiting lists and times.

- A non-partisan and expert Medicare Commission should be jointly appointed by the federal and provincial governments to reward provinces that meet objective performance indicators or that undertake reform that the Commission has identified as worthwhile.

- A permanent dispute settlement machinery should be created to deal with disputes over the interpretation of the program criteria in the CHA.

- Separate legislation is required to provide for national standards for insuring prescription drugs and home care. This legislation will likely have to take the form of a new shared-cost statute similar to the CHA, but with national standards for access rather than an outright prohibition on user charges.

Executive Summary

The *Canada Health Act* (CHA) has served Canadians extremely well since 1984. However, to continue to realize the values that lie behind the Act, some changes are needed.

In this paper, we propose significant reforms to the CHA. Three goals drive our recommendations: first, how to modernize the criteria of the CHA and expand its scope to better reflect the needs of contemporary society; second, how to give content to the criteria in the Act, cast as they are in very general terms; and, finally, how to overhaul federal-provincial relations in the health care sector.

A. Modernizing the Criteria: With regard to the five criteria, we recommend the following:

Universality: The criterion of universality is a fundamental principle and should be maintained for hospital and physician services and expanded specifically into diagnostic services. Through separate legislation there should also be universal coverage for prescription drugs and home care. The criterion of universality does not necessitate funding from general tax revenues but, rather, that funding is progressive (i.e., based on ability to pay). New national programs for home care and prescription drugs could be funded, for example, by compulsory social insurance.

Portability: Out-of-country coverage is not core to Medicare. The criterion of portability should be amended so that provinces are not in breach of the CHA if they do not pay for out-of-country treatment.

Public Administration: The criterion of public administration should be recast as "public governance and democratic accountability" to emphasize the importance of good governance and accountability of decision makers at all levels in Medicare. The federal government should monitor the growth of health care delivery by for-profit firms but acknowledge that the CHA does not preclude their participation, *provided services are fully publicly funded.*

Comprehensiveness: The CHA should require provinces to establish transparent and democratic *processes* to determine on an ongoing basis which services and goods should or should not be publicly funded. It should also require that provinces give priority to publicly funding services of proven effectiveness. As well, the scope of services protected by the CHA should be expanded to include all medically necessary diagnostic services. Consideration should be given to requiring provinces to integrate funding for *all* publicly funded health care services (whether protected by the CHA or not) and held by the appropriate level of decision maker.

Accessibility: If Medicare does not respond to Canadians' concerns regarding timeliness of treatment, support for it will be undermined and pressure for privately financed options will increase. The criterion of accessibility in the CHA should be changed to read "reasonable access in a reasonable time frame, given the nature of the health need," in order to incorporate a guarantee of timely access. The CHA should require the provinces to account for the processes they have in place to ensure that all residents of the province have access to health care goods and services in a reasonable time frame.

B. Extra-billing and User Charges: To prevent the emergence of two-tier health care and queue jumping, the prohibition on extra-billing should remain in place. Extra-billing would allow wealthier Canadians to queue-jump. There is no evidence from any country that allowing extra-billing will reduce waiting lists in public hospitals. On the contrary, countries like New Zealand and the United Kingdom that allow extra-billing and queue jumping have longer waiting lists in their public hospitals. Evidence shows that user charges for hospital and physician services may deter both unnecessary and necessary use of care. Thus the prohibition on user charges should remain in place unless a province could establish that a proposed regime of user charges would not deter Canadians from seeking the care they need, but only unnecessary care.

The CHA appropriately prevents experimentation with private financing through the prohibitions on user charges and extra-billing *but neither impedes nor encourages* reform or innovation in the *delivery* of health care. We think the CHA should be reformed to actively encourage innovation and evidence-based reform in the delivery of care.

C. Processes for Giving Content to the Criteria of the Act: Currently, the five criteria in the CHA are statements of the values that Canadians want to see reflected in provincial insurance systems across the country. There is, however, no substantive definition provided for crucial phrases such as "medically necessary" and "reasonable access." This is understandable, given that these kinds of requirements must vary over time and between provinces. To give real content to the values articulated in the CHA, the CHA should require provinces to demonstrate the *processes* they have in place to define and comply with the criteria on an annual basis. We believe that this approach would shift the focus of federal-provincial relations away from disputes over enforcement and pervasive acrimony toward a partnership between the federal and provincial governments. By shifting toward a system that focuses primarily on accountability for processes, we recognize that a one-size-fits-all approach may be appropriate to the *values* the system strives for, but not the various *means* of realizing those values.

D. Overhauling Federal-Provincial Relations in Health Care: Federal-provincial relations in health care are in desperate need of repair. To this end, Medicare requires the creation of two sets of joint federal-provincial institutions to govern it. First, we propose the establishment of a jointly appointed, non-partisan and expert Medicare Commission to work with the provinces to establish processes to better satisfy the criteria of comprehensiveness, accessibility, and public governance and accountability. The Commission would reward provinces that meet objective performance indicators or that undertake those reforms the Commission identifies as worthwhile. To effect real change in the system, the Commission would have to receive a significant sum of federal funds above and beyond existing transfer payments. Second, we propose the creation of permanent procedures under the Social Union Framework Agreement to deal with disputes over the interpretation of the CHA. Disputes would be heard by specialist panels. Moreover, in addition to being triggered by government complaints, the machinery could also be invoked directly by citizens.

E. National Programs for Prescription Drugs and Home Care: Separate legislation is required to provide for national standards for insuring prescription drugs and home care. This legislation will likely have to take the form of a new shared-cost statute similar to the CHA, but with

national standards for access rather than an outright prohibition on user charges. We believe that some user charges may be appropriate in a national home care system as home care straddles the medical care and social services sector, e.g., homemaking services may appropriately attract a user fee. In the case of prescription drugs, it is vital that Canadians not be deterred from obtaining necessary prescription drugs because of fees. But, for example, the imposition of a user charge upon a brand name drug as opposed to a generic drug would seem acceptable.

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I. Introduction and Overview

The *Canada Health Act*[1] (CHA) states that its purpose is to "establish criteria and conditions in respect of insured health services and extended health care services provided under provincial law that must be met before a full cash contribution may be made" (*CHA* 1985, sec. 4). But to view the CHA as simply a dry and dusty spending statute, whereby the federal government transfers funds to provinces that comply with certain conditions, belies the importance of the CHA in the hearts and minds of Canadians. For most Canadians, the CHA has become a document of near constitutional status, emblematic of Canadian values and a guarantee for all Canadians of the security of health insurance. The link between the CHA and Canadian identity is reinforced by the sharp contrast between the universal scope of Canada's Medicare program and the partial scope of health insurance in the United States (Naylor 1999, p. 24), where 16.3 percent of the population (OECD 2001, Table 146) is left without the day-to-day security of even the most basic health insurance coverage (Reed and Tu 2002).

In this paper, we explore how to modernize the CHA so that the values Canadians cherish in the distribution of health care will continue to be realized in the 21st century. We propose a number of significant reforms to the CHA. Our vision is ambitious, and the reforms proposed are sweeping in nature. We have two caveats for readers. First, we do not have space in this paper to work through in detail each proposed reform, or the mechanisms for their implementation, the latter being particularly critical. Second, we wish to stress that none of our proposals detract from a publicly funded health care system in which all Canadians are assured of access to the care they need. But notwithstanding our commitment to this fundamental principle, we do think that the means whereby this principle is achieved require change, which in turn, requires amendments to the CHA itself. The need for reform is particularly pressing because the prospects for enforcing the Act in its current form have been greatly diminished by federal-provincial conflict over the stability and level of financing. The CHA needs to be strengthened so it becomes a beacon for innovative reform and continual improvement as opposed to a lightning rod for dissent.

In the first half of the paper, we discuss the five criteria of the CHA (public administration, comprehensiveness, universality, portability, and accessibility) and whether or not these criteria satisfy the values and needs of contemporary Canada. We make several recommendations for clarifying and embellishing the five criteria. We also discuss the CHA's explicit prohibitions on extra-billing and user charges. As well, we discuss the enforcement of the CHA to date. Our most important recommendation arises from the difficulty that the federal government has had in enforcing compliance with the five criteria, some of which are described in very broad terms (e.g., what does it mean to require that provincial insurance plans be "comprehensive"?). We argue that accountability should focus primarily on the *processes* that provincial governments have in place to meet the five criteria. Different provinces will employ different means to achieve the values represented by the five criteria.

We also discuss the extent to which the CHA restricts the potential for innovative health care reform. We conclude that the CHA does not impede reform of the *delivery* of health care but does exclude experimentation with private financing. Moreover, we note that there is no

evidence that increased private financing would solve any of the problems that Medicare is currently experiencing.

Although we consider our recommendations regarding the five criteria to be critical, our most sweeping ones fall in the second half of the paper. These recommendations pertain to enforcing the CHA and respond to the dysfunctional relationship that has developed between the federal and provincial governments over the governance of health care. We propose the creation of a permanent, independent tribunal for resolving disputes as well as an independent, national commission that would reward provinces for engaging in innovative reform.

We also recommend creating separate legislation to provide national standards for insuring pharmacare and home care and discuss a number of constitutional methods for moving forward to create those standards. In particular, we recommend creating a new shared-cost statute similar to the CHA.

II. Assessing the CHA: Does It Satisfy the Values and Needs of Contemporary Society?

The CHA ensures full public funding for a range of hospital and medical services. The Act does so by requiring provinces to cover "insured health services," which it defines as all "medically necessary" hospital services, "medically required" physician services, and surgical-dental services that need to be performed in a hospital. To obtain federal funding contributions, each provincial insurance plan must meet five criteria: public administration, comprehensiveness, universality, portability, and accessibility. The CHA also expressly prohibits extra-billing and user charges for insured health services, and requires the federal government to withhold one dollar of federal funds for every dollar paid if provinces allow these practices. The five criteria and prohibitions *do not* apply to "extended health care services."[2]

For Canadians, these criteria and prohibitions have evolved into the touchstones of a just and fair health care system. We discuss below the relative importance of each and consider the extent to which they need to be clarified or amended to reflect contemporary needs. We first discuss universality, portability, and public administration – perhaps the least controversial of the five criteria. We then move on to (and spend considerably more time on) the far more difficult criteria of comprehensiveness and accessibility, the prohibitions against extra-billing and user charges, and problems of enforcement.

1. Universality

The criterion of "universality," under section 9 of the Act, requires a provincial plan to entitle 100 percent of qualified provincial residents to receive "medically necessary" hospital services and "medically required" physician services on uniform terms and conditions. Universality is a *fundamental* value that ensures a national plan for all Canadians. That said, the Canadian model (a universal plan funded by general taxation revenues) is not the only model that can provide the security of health insurance to all citizens. The Netherlands, for example, manages to achieve near universal coverage through compulsory *social insurance* for the poorer 65 percent of the population, while leaving the remaining 35 percent to purchase private insurance. Social insurance is funded *progressively* (i.e., according to people's means) by employer and employee contributions, which are a percentage of annual income. And through extensive regulation, the Dutch manage to ensure functional equivalence between the coverage provided by social and private insurance (Flood 2000*a*, Chap. 3). However, the Dutch system is not clearly so much more efficient than the Canadian one that we should abandon our principle of universality when it comes to core services such as hospitals and physicians. Nor is it clear that reforming the Canadian system along the lines of the Dutch system (with its mixture of private and social insurance) is feasible, given the historical development of Canada's health care system. Canada has neither a long history of sickness funds and social insurance nor a commitment to what the Dutch call "social solidarity," a value that enables them to harness both the private and quasi-public sphere in pursuit of the public interest. Thus we would recommend that a modernized CHA retain its core commitment to universal coverage for hospital and physician services.

A commitment to universality, however, does not necessarily mean a commitment to funding universal coverage from general taxation revenues. Indeed, the CHA does not require this, although most provinces have opted to fund health insurance in this way. International experience demonstrates that it is possible to achieve universal coverage through a variety of means – public financing through general taxation revenues, social insurance (i.e., funding through compulsory premiums), and the regulation of private insurance. Within Canada, the provinces are already experimenting with different mechanisms for providing universal coverage for services and goods outside the rubric of the CHA. For example, Quebec has put in place a pharmacare plan that ensures coverage for all citizens by regulating private insurance schemes and requiring contributions by employers and employees as a fixed percentage of annual income. We think there could be future benefits if Canada were to experiment with *different* methods of achieving universal coverage. Below we argue for new federal legislation that would provide national standards for the insurance of pharmacare and home care. Like the CHA, such legislation would not require health care to be funded from general taxation revenues. But unlike the CHA, it should explicitly permit provincial insurance plans to be funded progressively through employer and employee contributions, as long as coverage is universal. Indeed, there may be a significant benefit to moving to premiums, because separating funds for health care from general taxation revenues would assist in ensuring the stability of funding. It would also reduce the tension between the drive to increase public spending on health and the desire to cut taxation rates. Moreover, as private insurers already have a significant presence in the market for insuring prescription drugs and, increasingly, home care services, requiring them by law to achieve universal access is unlikely to raise the expropriation provisions under NAFTA, whereas nationalizing them clearly would (Epps and Flood 2002).

Recommendations

1. The criterion of universality be maintained for hospital and physician services.

2. As we develop national standards for insurance programs covering pharmacare and home care, that there be a requirement for universality and for progressive funding, but not necessarily from general taxation revenues.

2. Portability

Section 11 of the CHA requires a province's plan to insure all residents within three months of arrival in the province. In terms of interprovincial portability, plans must pay for the cost of services used by residents who travel to other Canadian provinces at the rate approved by the plan of the province in which the services are provided or by agreement otherwise. In terms of Canadians visiting foreign countries, provincial plans must reimburse at least the amount that would have been paid for similar services rendered in the province. Sections 11(2) and (3) provide that the portability criterion is not contravened by a requirement that a patient obtain consent from the provincial plan before receiving non-emergency care when in another province or country.

Quebec breaches the portability criterion by refusing to compensate for health care services that its residents receive in other provinces. Five other provinces breach the requirement that they reimburse the cost of services provided outside of Canada at a rate similar to the one paid for services rendered in the province (Canada Office of the Auditor General 1999, Chap. 29). Eliminating the requirement for out-of-country coverage would not offend, in our opinion, the core principle of fairness that underlies the CHA, as it is reasonable to assume that Canadians who can afford to travel to foreign jurisdictions can also afford to purchase travel insurance. Moreover, we think the coverage currently provided is likely to cover only a small percentage of the total costs incurred by cross-border travelers, for example, to the United States. The existence of even some coverage by provincial plans may provide a false sense of security to Canadian travelers and deter them from purchasing full private travel insurance. Other countries such as the United Kingdom, New Zealand, and Australia, do not provide out-of-country coverage for emergency services unless they have negotiated reciprocal agreements with the country in question and are able to ensure that their citizens are *fully* covered for the costs.[3] For these reasons, we believe the requirement for provinces to insure out-of-country treatments should be deleted from the portability requirement. Of course, the elimination of this requirement from the CHA would not prevent any province from electing to provide out-of-country coverage as an additional benefit for its citizens.

Recommendation

The criterion of portability be amended to eliminate the requirement that provinces pay for out-of-country treatment.

3. Public Administration

The CHA has become an icon of Canadian values, yet its actual content is poorly understood. This is most true of the requirement of "public administration." This criterion requires that the plan be "administered and operated on a non-profit basis by a public authority appointed or designated by the government of the province" (*CHA* 1985, sec. 8(1)(a)). Notably, it does *not* require that all *providers* be either non-profit or public. Thus the public administration criterion does not prevent a province from contracting out the delivery of publicly funded services to private, for-profit providers. In fact, for-profit providers such as physicians have long been central to the system. To be sure, some have argued that allowing physicians to operate on a for-profit basis is significantly different from contracting out to for-profit firms responsible to shareholders (Evans et al. 2000). However, there is nothing in the CHA to prevent private, for-profit providers from participating in the publicly funded system, whether they are physicians or firms. Moreover, we would submit, the participation of private, for-profit firms (e.g., for-profit hospitals or laboratories) does not contravene the underlying values of the CHA, provided the services delivered are *fully publicly funded*.

Notwithstanding the permissibility of contracting out to private, for-profit entities under the CHA, interest groups continue to oppose these sorts of reforms by arguing that they contravene the Act. These objections attract support because no crisp distinction is made in public discourse

between financing (which the CHA appropriately safeguards as public) and delivery (which has historically always been a mixture of public, not-for-profit and private, for-profit providers). The unspoken concern behind the opposition to private, for-profit firms may be that by condoning the participation of for-profit providers, we are on a slippery slope toward more private financing in the system. We do not doubt there would be significant regulatory challenges if there were a significant increase in the number of private, for-profit firms operating in the health care sector, particularly in acute care. Also, given the evidence that for-profit hospitals in the United States are associated with higher mortality rates than not-for-profit hospitals, most provinces are unlikely to facilitate the introduction of a large for-profit hospital sector (Devereaux et al. 2002). However, a strong commitment to full public funding, along with rigorous enforcement of the prohibitions on extra-billing and user charges, should be sufficient to keep a check on for-profit firms trying to circumvent the restrictions of public financing or trying to create *de facto* a two-tier system. If we are not correct in this prediction, then the CHA may have to be revisited. For the time being, there seems to be sufficient evidence both for and against for-profit provision in different spheres that this matter is best left to each province's discretion.

We also question whether "public *administration*" is as fundamental to Canadian values as "public *governance*." The Act currently allows provinces to "designate any agency to receive ... any amounts payable... and to carry out on its behalf any responsibility in connection with the receipt or payment of accounts rendered for insured health services" (*CHA* 1985, sec. 8(2)(a) and (b)). The public administration criterion, as it is currently configured, *implies* a *passive* insurance model, where governments simply administer and process claims made by physicians and hospitals for services provided. The assumption underlying this language is that all care prescribed and provided by physicians must be "medically necessary" and therefore should be publicly funded. This kind of language is at odds with the contemporary practice of health care systems. In response to ever-increasing costs in health care, insurers around the globe, whether public or private, increasingly use a variety of techniques (sometimes called managed care) to try to influence the allocation decisions made by physicians (Flood 2000*a*). Thus to speak of public *administration* belies the significant *governance* role that provincial governments need to take in managing and regulating their respective health care systems. Also, the criterion of public administration, as it is presently worded, could be interpreted as reducing the flexibility that provinces need to experiment with different management models. Should provinces be prevented from contracting with private, for-profit organizations to manage publicly funded health insurance plans? Would it contravene the criterion of public administration if provinces were to devolve budgets to groups of doctors (who are private, for-profit providers) and require those groups to manage these funds? Although we do not think the current wording of the CHA would prevent this kind of managerial innovation, ongoing disputes over these kinds of questions could be avoided if the criterion of public administration were updated by amending it to "public governance."

There are other reasons to prefer the word "governance" over "administration." When we speak of governance, we begin to get to the heart of what has been lacking in the Canadian system and what is required to ensure sustainability. In our opinion, the most significant problem is a failure to commit to strong governance and accountability for decision making (Choudhry 2000; Flood 2000*a*, Chap. 4; Institute for Research in Public Policy 2000; and Flood 2000*b*). Here, we do not mean accountability solely for dollars spent, but accountability to citizens for

how the system is governed and for the delivery of timely and high-quality health care. We are thinking of democratic accountability: how to ensure that the State, and decision makers empowered by it, take responsibility for the decisions they make, and are accountable in a fair and more direct and timely manner than is possible through elections every four or five years. This could take a variety of forms and will differ from province to province. For example, provinces might choose to devolve and decentralize decision making closer to affected communities, make consultation mandatory, elect regional health authorities, ask citizens to choose primary care groups, establish patients' bills of rights, or create patient ombudspersons (Flood 2000*a*, Chap. 4; Institute for Research in Public Policy 2000; and Flood 2000*b*). The federal government could take a lead here by amending the CHA to include a richer definition of public administration, namely "public governance and democratic accountability." Some might argue that our logic is circular here, for if "public administration" is not clear, then neither is "public governance and accountability." However, as we discuss below, the primary mechanism for enforcing public governance and democratic accountability should be asking the provinces to account for the *processes* they have instituted to improve public governance and democratic accountability. Thus the provinces themselves will flesh out the meaning of the criterion through governing their respective plans. They will, in effect, bind themselves through this process.

To further the accountability of federal and provincial governments, we also recommend that the federal government be held to account for the total sums transferred to the provinces for health, and the provinces for the spending of all federal transfers. To facilitate this, it is vital that health care transfers be decoupled from transfers for social assistance and post-secondary education under the Canada Health and Social Transfer (CHST). In its stead, there should be a separate federal transfer, which we would call the "Canada Health Transfer." Whatever benefits there are from the flexibility of consolidating federal funds are overwhelmed, in our view, by the loss of accountability for expenditures on health.

Recommendations

1. The federal government monitor the growth of health care delivery by for-profit firms but acknowledge that the CHA does not preclude their participation, *provided services are fully publicly funded.*

2. The criterion of public administration be recast as "public governance and democratic accountability."

3. The CHA require provinces to account for the processes they have in place to further improve public governance and democratic accountability within their systems.

4. Federal transfers for health be separated from other transfers to ensure clear lines of accountability on the part of federal and provincial governments.

4. Comprehensiveness

If a health insurance plan fails to cover what society considers necessary care, it will ultimately lose legitimacy in the eyes of the public. Failure to ensure comprehensive coverage will also diminish the incentive of wealthy Canadians to support the plan politically and their wish to remain in it (Hirschman 1970; Flood 2000*a*). We approach the difficult issue of comprehensiveness in the following stages:

(a) How provinces determine which hospital and physician services are publicly funded;

(b) The accountability of provinces for their processes to decide which hospital and physician services are publicly funded;

(c) What the CHA could do to make *effective* health care services the priority for public funding;

(d) How the CHA fails to cover important health care services such as prescription drugs and home care; and

(e) How to ensure the integration of funding and delivery of care for a broader range of services than those protected by the CHA.

(a) How Provinces Determine Which Hospital and Physician Services Are Publicly Funded

Which hospital and physician services are publicly funded turns on the interpretation of the phrases "medically necessary" and "medically required." However, these key phrases are not defined in the CHA and have also not been defined operationally in provincial legislation (Canada Royal Commission on New Reproductive Technologies 1993, p. 80). In practice, provincial governments and medical associations negotiate which services are to be publicly funded in the process of determining the fees that physicians will receive in exchange for providing services. This method attributes a great deal of power to physicians and reflects the accord reached between physicians and governments at the time the foundations of Medicare were established, i.e., that physicians would accept public insurance provided that public insurers did not interfere with their clinical autonomy (Tuohy 1999). The decision process has been primarily a one-way highway, with new services being added to the list that is publicly funded and few removed. More recently, there has been some movement in the opposite direction. Increasingly, provincial governments are "delisting" certain services on the ground they are not "medically necessary" or "medically required." As with the decision to publicly fund a service, the decision to delist is made jointly by provincial governments and medical associations. In Ontario, for example, a "Physician Services Committee," composed of representatives of the Ministry of Health and Long-Term Care and the Ontario Medical Association makes delisting decisions.

(b) Accountability of Provincial Decision Making Regarding What Services to Publicly Fund

Presently both the process of deciding which services to fund and the process of delisting rely on provincial governments to represent public values and on physicians to apply technical expertise.[4] However, there are strong arguments that this is an impossible task because, at present, the process for determining what is "medically necessary" is too intimately connected to the process for determining compensation rates for physicians.

Should we amend the CHA to include a substantive definition of "medically necessary"? The difficulty is that what goods and services are "medically necessary" change over time as technology, resources, and values change (Caulfield 1996). Rather than trying to nail down a definition, which will inevitably be superceded, it is more important to develop better *processes* for determining what is or is not "medically necessary."

A recent report commissioned by the Premier of Alberta (the Mazankowski report) has called for the establishment of a permanent, expert, and independent panel to determine which services are or are not medically necessary and, therefore, publicly funded (Klein 2001). If implemented and made truly transparent, this initiative would be a significant improvement over the existing system where these decisions are made behind closed doors by provincial governments and medical associations. We advocate that the CHA be amended to require all provinces to establish transparent, democratic, and accountable processes to determine on an ongoing basis what should be covered in the public system.[5]

An important issue is whether or not the decision-making process for determining what is "medically necessary" could be used as a method to whittle away the core of publicly funded services. Except for services such as cosmetic surgery and infertility treatments, the custom has been to publicly fund in full hospital and physician services if "medically necessary." Moreover, it has traditionally been thought that services that are not "medically necessary" and hence not publicly funded would not be provided by the *private sector*, because there would be no demand for medically unnecessary services. However, while services may not be beneficial enough to warrant public funding, there is increasing recognition that patients may still benefit from them enough to wish to buy them. This kind of approach raises concerns about creating a two-tier system, an issue we discuss further under extra-billing. It also raises potential conflicts of interest for physicians who work in both the public and private systems and, who, at least in the absence of sophisticated regulation, would have a financial incentive to shift patients into a privately financed system for their services. This is particularly a concern if, as the Alberta government is planning, the intention is to encourage supplementary private insurance to help provide coverage for services that are not "medically necessary" but still considered sufficiently beneficial.

Concerns that the process of deciding what is "medically necessary" is being used to whittle away at the scope of publicly funded services suggests we may need to redouble our efforts to find a substantive definition of "medically necessary." On balance, however, we think that by requiring provinces to establish transparent, democratic, and accountable processes, the core of Medicare will be protected. With such processes in place, the experience both domestically and internationally is that there is no political will to significantly reduce the range of publicly funded hospital and physician services (Flood, Stabile and Tuohy 2002; Jacobs, Marmor and

Oberlander 1999). Once the prospect of rationing services is made explicit and transparent, citizens will not be prepared to exclude patients from getting the health care services they need. Also, at the limit, the federal government can claim that a province is delisting services that are medically necessary and withhold federal transfers. As we argue below, the reasonableness of the federal government's interpretation could be reviewed by an independent dispute resolution tribunal.

(c) What the CHA Could Do to Make Effective *Health Care Services the Priority for Public Funding*

Whatever process is used to determine which services are publicly funded, it must be noticeably generous in its inclusion from the start. Why is this? On average, we may conclude that a certain kind of procedure or test is not "medically necessary" for a population. However, it will always be the case that for certain patients in certain circumstances a particular kind of procedure or test will be by far the most cost-effective and appropriate treatment. Thus being too utilitarian in our calculations will lead both to inequity and frustration with the system on the part of physicians and their patients.

On the other hand, our present system, which gives physicians complete control over allocating public funding to a very broad range of services, results in the provision of some services for which there is little or no evidence of effectiveness. Estimates of the cost of inappropriate use generated by physicians vary but are sometimes as large as 30 to 40 percent of the cost of all services (Stoddart et al. 1993, p. 6). For ordinary Canadians, this may be hard to understand given the difficulties many have in accessing care, but variations in the number of health services supplied in communities without different health needs support this contention (Roos and Roos 1994; Canada National Forum on Health 1997, p. 20). For example, there are significant variations in the number of hysterectomies performed in Ontario, with no underlying objective clinical reason why there should be such wide variations, and with no apparent difference in patient outcomes (Coutts 1998). The goal of the publicly funded system should be to encourage the delivery of health care for which there is *evidence of effectiveness*. While the CHA states this goal implicitly by requiring provinces to determine what is "medically necessary," it needs to be more explicit so that the process is disentangled from the one to determine remuneration for physicians.

(d) The CHA's Failure to Cover Prescription Drugs and Home Care

The CHA does not protect what have become very important health care services: prescription drugs, medical equipment, or diagnostic services used outside of hospitals; ambulance services; dental care; and home care services. By giving primacy to "medically necessary" hospital services and "medically required" physician services, the Act skews public financing toward those services. The systemic impact is that hospital and physician services receive high rates of public funding (91.1 percent and just under 99.0 percent, respectively), while prescription drugs, for example, are funded at a rate of just 36 percent (Canadian Institute for Health Information 2001). Canada may seem to be a model for ensuring fair access to physician and hospital services, but, among developed OECD countries, it stands in the odd

company of Mexico, the United States, and Turkey in not ensuring universal access to prescription drugs (Jacobzone 2000; Willison et al. 2001).

The principles of the CHA, laid down in the 1950s and 1960s, have served Canadians extremely well over the decades. Now, however, advances in technology and changes in demographics have revealed the system's inflexibility. There is now less need for health care services to be delivered in hospitals and much greater need for prescription drugs and home care services outside the hospital, neither of which is consistently publicly funded. The core value that lies behind the criterion of comprehensiveness is that people should have access to needed services. Most Canadians would probably agree that it is more important for people with diabetes to get insulin than an annual general checkup, but the CHA does not currently reflect that value because it requires full public funding of the latter (if medically required) but not the former. Moreover, those people who have private insurance for prescription drugs are more likely (all other things being equal) to use more publicly funded physician services (Stabile 2001).

To ensure that Canada's health care system is comprehensive, we believe it is essential to create national standards for insuring prescriptions drugs and home care. The most feasible way to do so, in our opinion, is to create companion legislation to the CHA, which would be enforced through conditional federal transfers. This companion legislation would allow provinces more flexibility to experiment with the mix of public and private financing (including user charges) than the CHA allows. At the same time, companion legislation (which we might call the "Canada Pharmacare and Home Care Act") would have to contain minimum standards regarding access e.g., the income level below which user charges are unacceptable. We discuss our reasoning more fully below.

In addition to promulgating companion legislation to provide national standards for insuring prescription drugs and home care, we would like to amend the CHA to cover all medically necessary diagnostic services such as magnetic resonance imaging (MRI) and genetic testing that, with advances in technology, need not be delivered within hospital walls or under the supervision of a physician. Clearly, if a two-tier system developed for diagnostic services, then people who could afford to purchase diagnostic services in the private sector would also be able to gain quicker access to publicly funded hospital and physician services that require the prior use of diagnostic tests.

(e) Integration of Funding

Part of the problem in not providing full public funding for prescription drugs and home care services is that this results in different sources of funding for health care services, which leads to separate standards in delivering care and opportunities for cost-shifting (e.g., cash-strapped decision makers in the public system will, if feasible, shift costs to others). The funding and delivery of the full range of health care goods and services (hospital, physician, drugs, diagnostic services, home and community care) must be integrated into budgets held by appropriate decision-making bodies (regional health authorities, hospitals, and primary care teams). The CHA may only require 100 percent of "medically necessary" hospital and "medically required" physician services to be publicly funded, but it does not preclude provincial governments from

integrating this spending with other public funding for programs such as prescription drugs and home care. For example, experiments with integration through regionalization cannot be completed until funding for physicians and prescription drugs are included in these regional budgets (Lomas 1999). In our opinion, the CHA could help break the lock of physicians opposed to regional authorities holding budgets for physician services. This could be done by requiring the provinces to integrate funding for publicly funded health care services (whether covered by the CHA or not) and ensure that such funding is held by the appropriate level of decision maker.

Recommendations

1. The CHA require provinces to establish transparent, democratic and accountable processes for determining which services and goods should be covered by Medicare.

2. The CHA stipulate that, in general, provinces give priority to publicly funding services of proven effectiveness.

3. Companion legislation to the CHA should provide national standards for public insurance of prescription drugs and home care. It is imperative that companion legislation provide for access standards, e.g., maximum income levels below which user charges may not be imposed. This proposal is discussed more fully in the second part of the paper.

4. The CHA be amended to provide protection for all medically necessary diagnostic services, wherever provided.

5. The CHA should require provinces to integrate *all* public funding for health care services (whether covered by the CHA or not) and ensure that such funding is held by the appropriate level of decision maker.

5. Accessibility, Extra-billing and User Charges

Accessibility is a fundamental component of any insurance program, as having insurance coverage is an empty right without access to services. Section 12 requires provinces to ensure that Canadians have "reasonable access" to services that physicians are paid "reasonable compensation" for services "rendered," and that hospitals are paid for "the costs of insured health services." In addition to section 12, sections 18 and 19 ensure access to health care on the basis of need and not the ability to pay by prohibiting extra-billing and user charges.

(a) Do the Provisions of the CHA Prevent Innovative Health Care Reform?

We first address whether the accessibility criterion and the prohibitions on extra-billing and user charges prevent innovation in health care reform. The CHA appropriately prevents experimentation with private financing through the prohibitions on user charges and extra-billing but it *neither impedes nor encourages* reform or innovation in the *delivery* of health care. We

think the CHA should be reformed to actively encourage innovation and evidence-based reform in the delivery of care.

One of the most consistent criticisms of the Canadian system is its reliance on physicians who work in solo and are paid on a fee-for-service basis. Report after report has spoken of the need for "primary care reform" that would require physicians to work in teams with other health care providers such as nurses to provide continuous primary care.[6] These reports also recommend changing the way doctors are paid to eliminate the financial incentive in the existing system to focus on the quantity rather than the quality of care. The language in section 12 – "reasonable compensation" for services "rendered" by physicians – implies indemnity insurance (where all costs incurred are covered without question), with physicians reimbursed on a fee-for-service model. However, it is important to note that while the CHA *assumes* a certain model of insurance and payment, it does not require it. Thus there is flexibility within the CHA for provinces to employ different payment mechanisms. The CHA has certainly not prevented every province in Canada, over the course of the 1990s, from experimenting with different payment arrangements in primary care (Hutchinson, Abelson and Lavis 2001, p. 121). The slow rate of progress in this regard is not attributable to the CHA but to other factors, such as lack of political will, lack of accountability for good governance and management, and resistance on the part of some in the medical profession.

As we discuss further below under extra-billing and user charges, the most important sections of the CHA are those that prohibit private financing for necessary medical and hospital services. There is, however, no prohibition in the CHA to prevent health care reform in the *delivery* of health care services.

(b) "Reasonable Access"

As with the term "medically necessary," the CHA does not define what "reasonable access" is. There are no explicit statements about what "reasonable access" means, such as guidelines for ratios of patients to physicians or distance from hospitals. What is "reasonable" depends, of course, on a number of factors, including the resources available to society, societal values, the type of health care need, and changes in technology. As these factors change over time, it is fruitless to attempt to provide a substantive definition of "reasonable access" within the CHA. As with comprehensiveness, the path forward is for the CHA to require provinces to account for the processes that they have in place to ensure that all residents of the province have reasonable access to health care goods and services.

(c) No Specific Commitment to "Timely" Treatment

There is no explicit requirement in the CHA for Canadians to have access to "timely" care, although this could be inferred from the term "reasonable access." Timeliness of care and concerns about waiting lists have received considerable media attention. Growing waiting times impose greater private costs on Canadian patients in terms of days off work, lost productivity, and so on. As these costs are not covered by the public purse, there may not be sufficient

incentives within the existing system to control them. That being said, compared to other countries like the United Kingdom and New Zealand (which allow extra-billing and a two-tier system), Canada has a significantly smaller proportion of its population on waiting lists (Tuohy, Flood and Stabile 2001) and, on average, patients have to wait for a much shorter time for treatment. For example, one study compared waiting times for coronary bypass between New Zealand in 1994-95 and Ontario in the same period, and found that the New Zealand mean and median waiting times (232 and 106 days, respectively) were significantly longer than the Canadian mean and median (34 and 17 days, respectively) (Jackson, Doogue and Elliot 1999). It is also unclear how serious the waiting list and time problems truly are in Canada (O'Brien 1998). Nonetheless, the existing data, as flawed as they may be, do suggest that waiting times are increasing (Walker and Wilson 2001). Perhaps more importantly, Canadians themselves are convinced that they have to wait longer for care – a 2001 survey found that 52 percent of Canadians thought that waiting times were either slightly or much longer than they had been five years before (PriceWaterhouseCoopers 2001). Canadians are accustomed to speedy and efficient service in all other spheres of life; they can be expected to demand it in health care as well. As Michael Decter writes, "[i]n every walk of life the consumer's desire for speed has brought about a transformation, be it fast food or fast entertainment" (2000, p. 7). If Medicare does not respond to Canadians' concerns regarding timeliness of treatment, support for it will be undermined and pressure for privately financed options will increase.

In our opinion, accessibility means little unless we speak of access to timely care. The CHA criterion of accessibility should be broadened to read something like "reasonable access in a reasonable time frame, given the nature of the health need." Again, the meaning of "reasonable time frame" cannot and should not be rigidly defined in the CHA. Instead, the CHA should require the provinces to account for the processes they have in place to determine what is "reasonable."

(d) Extra-billing and User Charges

In addition to the criterion of "accessibility" provided for in section 12, the CHA also seeks to ensure accessibility through sections 18 and 19 of the Act. Respectively, these sections require provincial plans to prohibit "extra-billing" and "user charges" to qualify for federal contributions. A "user charge" is a charge made to a patient that the patient must pay out of his or her own pocket to cover a portion or the entire price of health services. So, for example, if patients were required to pay $10 every time they consulted a physician, this would amount to a user charge. "Extra-billing" is a concept closely related to user charges where a physician (or any other health care provider) supplements his or her income by billing the patient or the patient's private insurance company for publicly insured health services *in addition to* receiving sums from the government (Flood 1999).

i. Extra-billing and a Two-tier System

Sections 18 and 19 of the CHA are largely what make Canada unique in how it allocates health care and reflects a communitarian ideal (we are all in this together) (Flood 2000*a*,

Chap. 2). In many countries, physicians and hospitals are free to bill patients covered by public insurance plans for amounts above and beyond those laid down in the government fee schedule. Moreover, they are also free to provide services on an entirely private basis that are covered by the public system but for which there may be lengthy waiting lists. This capacity allows a two-tier system to flourish, in which physicians are allowed to work in the public sector and to top up their incomes by working in the privately financed sector. In countries such as the United Kingdom and New Zealand, some people have supplementary private insurance that provides coverage for (a) extra-billing in connection with publicly insured services and/or (b) purchasing private health care services that are also available in the public system but for which there are queues.

In Canada, provinces have taken a variety of regulatory approaches, all designed with a view to creating strong disincentives against (if not outright prohibiting) a private system that requires cross-subsidization from the public system (Flood and Archibald 2001). In all provinces, physicians can opt out of the public system and operate wholly in the private sector – but they cannot work in both. The result is that private markets for health care in Canada only distribute services that receive no public funding at all, such as cosmetic surgery and in vitro fertilization. Unlike in the United Kingdom, Australia or New Zealand, people in Canada do not have the choice of buying a service such as a hip operation from the private system just to jump the waiting list in the public system.

There is ongoing debate about the equity and efficiency of extra-billing and whether or not a two-tier system should be allowed to operate in Canada. After reviewing the international evidence, Tuohy, Flood and Stabile recently concluded that a two-tier system would reduce equity. They saw no evidence that a parallel private system would reduce pressure on the public system by, for example, reducing waiting lists (Tuohy, Flood and Stabile 2001). In fact, countries with two-tier systems such as the United Kingdom and New Zealand recorded much longer waiting lists and timelines than Canada. There was also no evidence that increased private financing would relieve any of the other problems that beset the Canadian health care system and others around the globe.

ii. User Charges

In any debate addressing the validity of user fees, it is important to establish what the goal is. Is the goal:

1. to act as a brake on use of services and reduce overall health care spending; or
2. to generate additional private funds for health care?

If the goal is the latter, the experience in the United States amply demonstrates that more private financing does not result in a better system *per se*, measured either by equity or efficiency.

The imposition of user charges on patients does not take account of the fact that it is primarily *physicians* who make recommendations to patients about what care is needed and that patients rely on their physicians' advice. If this assumption is generally true, then user charges

may not result in more appropriate use of services. If a patient faced with a user fee attempted to self-diagnose, he or she might believe – mistakenly – that the condition is not serious and not seek appropriate treatment, which could result in a crisis and greater costs later on. Also, if the goal is to decrease spending by reducing use, user charges will not be effective if private insurance completely covers the cost of the user charge.[7] Finally, total health spending will not decline if physicians in a fee-for-service system respond to a decline in demand by simply providing more services to those patients who can afford them or who have private insurance (Epp et al. 2000; Rice and Morrison 1994; Stoddart et al. 1993; Flood 1996, p. 1-3; Hutton 1989; and Deber 2000*a* and *b*).

From an equity and fairness perspective, user charges are obviously of concern, as they are contrary to the core principle that access to needed health care services should be distributed on the basis of need and not the ability to pay. A regime of user charges could satisfy this principle only if generous safety nets were constructed so that people on low incomes were not deterred from seeking the care they need; otherwise, there would be concern about the adverse impact on the health of low-income people (Tamblyn et al. 2001). Any province that wanted to impose a system of user charges would have the heavy burden of demonstrating that the charges would not prevent people from receiving the care they really need.

Recommendations

1. The criterion of access in the CHA be changed to "reasonable access in a reasonable time frame, given the nature of the health need."

2. The CHA require the provinces to account for the processes that they have in place to ensure that all residents of the province have reasonable access to health care goods and services in a reasonable time frame.

3. The prohibition on extra-billing remain in place.

4. The prohibition on user charges remain in place.

III. Enforcement of the CHA

1. Introduction

The federal government can enforce the terms of the CHA by withholding federal funding from the provinces. There are two enforcement tracks. The discretionary enforcement track applies to the five criteria, and provides that the federal government *may* (but need not) deduct monies from provincial transfer payments for violations of the criteria (*CHA* 1985, sec. 14-15). Even if the federal government decides to make a deduction, the amount is that which "... the Governor General considers to be appropriate, having regard to the gravity of the default" (*CHA* 1985, sec. 15(1)(a)). The mandatory enforcement track applies to the specific bans on extra-billing and user fees, and provides, pursuant to section 20, the Minister of Health *must* deduct, on a dollar-for-dollar basis, the amounts paid as extra-billing or user charges for services that should be freely available.

Enforcement efforts have been checkered (Choudhry 1996; 2000; Flood 1999). The discretionary enforcement track has never been used despite the Auditor General's finding in 1999 that there were several cases of ongoing non-compliance with the five criteria of the CHA (Canada Office of the Auditor General 1999, Chap. 29, paras 29.45-29.49). For example, Quebec remains in breach of the portability requirement because it refused to reimburse patients for care received in other provinces at the amount that the other province would normally pay. Another study, relying on media reports and Hansard, suggests that many alleged violations of the CHA have not prompted a public response by the federal government (Choudhry 2000). Despite this, the federal government has not exercised its right to impose financial penalties.

In contrast, under the mandatory enforcement track, approximately $245 million were withheld from the cash contributions to seven provinces between 1984 and 1987. As provided for in the CHA, this money was returned to the provinces once they had eliminated the user charges. From 1992 to 1995, $2 million were deducted from transfer payments to one province that permitted extra-billing. Pursuant to the federal policy on private clinics (Marleau 1995), a total of approximately $6 million have been withheld since November 1995 from four provinces where patients were charged a "facility fee" for medically necessary services. One province is still not in compliance and is being penalized in the amount of $4,780 per month. Pursuant to section 20(6), the federal government could withhold additional sums beyond the amount of the facility fees; however, to date it has not chosen to do so (Canada Office of the Auditor General 1999, Chap. 29, paras 29.45-29.49).

2. Why Is the CHA Not Enforced More Vigorously?

Why is the CHA not enforced more vigorously? Why, for example, does the federal government refrain from using its discretionary powers to impose heavier financial penalties in the case of extra-billing or user charges, where deductions on a dollar-for-dollar basis do not result in provinces moving quickly to eradicate these activities? Also, why has the federal government *never* penalized a province financially for failing to comply with the CHA's five criteria?

(a) Lack of Deductions Does Not Necessarily Mean Lack of Enforcement

The fact that few deductions are being made does not necessarily mean that the CHA is not being enforced through alternative means. The Auditor General notes that the federal government tries to resolve issues of non-compliance through political negotiation rather than penalizing the provinces through financial sanctions. Over the last five years, six cases of non-compliance have been resolved using this approach. However, the Auditor General was concerned about delay in resolution, as four cases had taken between 14 and 48 months to be resolved, and two cases had continued for as long as five years without penalty (Canada Office of the Auditor General 1999, Chap. 29, para. 29.46). In sum, there is a lack of transparency here, making it extremely difficult to draw a definitive conclusion regarding the extent of federal enforcement activity.

(b) Inherent Difficulty of Enforcing Criteria

Although the federal government has withheld funding where provinces have allowed extra-billing or user charges, it has never withheld funds under its discretionary powers for breach of one of the five criteria. This is likely due in part to the difficulty in determining whether any of these criteria have been substantively breached. Whether or not a province has complied with the criteria of comprehensiveness or accessibility, for example, is easily debatable. As discussed earlier, these criteria are couched in general terms and their definitions are circular – comprehensiveness, for example, means that all insured services must be insured. This definition begs the question of what, at a minimum, must be covered. We advocate that the primary approach to the CHA should not be one of enforcing criteria as goals in themselves but of asking provincial governments to account for the processes they have in place to achieve these goals.

(c) Reductions in Federal Contributions in the 1990s

It is widely thought that the federal government's ability to enforce compliance with the CHA's criteria has been seriously diminished by reductions in federal *cash* transfers (Choudhry 2000). At the inception of Medicare, the federal government contributed 50 percent of all costs. The provincial and territorial ministers of health report that the federal share of provincial health costs was, on average, 10.2 percent in 1998-99, although one-time federal transfers in 1999-2000 and 2000-01 brought the federal cash contribution up to 13.8 percent (Provincial and Territorial Ministers of Health 2000, p. 19). The federal government argues that its contribution is actually significantly higher than this – approximately 30 percent – if tax point transfers are taken into account.

Apart from the *quantity* of the federal contribution, another significant concern for the provinces has been to ensure the *stability* of federal funding in provincial insurance plans.[8] Rapid reductions in federal funding undoubtedly caused significant hardships for the operation of provincial insurance plans in the early to mid 1990s, because, of course, funding reductions are not mirrored by reductions in health care needs or patient and provider expectations.

The turmoil over funding, and the resulting tense and bitter federal-provincial relations that have ensued, must to some extent have had an impact on the willingness and capacity of the federal government to impose its own vision of Medicare upon the provinces. Increasingly, a number of provinces are saying that the federal government has failed to show leadership in health care issues, and that, in the absence of significant financial contributions, it can no longer count itself a significant player in charting the future direction of Medicare in Canada. This state of affairs is completely unsatisfactory, and it is imperative to rebuild and restore a functional relationship between the federal and provincial governments.

Sophisticated governance is fundamental to solving many of the challenges that Canada's health care system faces. The present situation is characterised by blame, cost shifting, and "sterile, childish bickering" (Institute for Research in Public Policy 2000). Governance in health care is in a state of paralysis, as both provincial and federal governments find it more politically expedient to blame each other for Canadians' concerns about Medicare than do something about it. How unsatisfying and difficult the health portfolio has become is arguably reflected in the high turnover of health ministers. The Canadian Institute for Health Information reports that since 1990, 75 health ministers have served at the federal, provincial or territorial levels across the country with an average median term varying from a low of 13 months in the Northwest Territories to 41.5 months in Alberta (Canadian Institute for Health Information 2001, p. 54).

We now turn to proposing new methods of institutional oversight that could revitalize federal-provincial relations.

IV. Institutional Oversight

1. Introduction

The allocation of institutional responsibility for the oversight of national standards lies at the heart of the federal-provincial conflict over the future of Medicare. Currently, the responsibility lies exclusively with the federal government. The advantage of the current arrangement is that final responsibility for enforcement lies with the federal cabinet, which, in theory, can impose a significant financial sanction to elicit corrective action on the part of a province. The federal cabinet also has discretion to fine-tune the sanction and tailor it to political realities. However, as we noted earlier, the federal government has never used its discretionary power to withhold funds for the breach of any of the five criteria.

Even though the federal government's powers of enforcement lie largely unused, the provinces oppose the vesting of this responsibility with the federal government, for a variety of reasons:

- Unilateral federal enforcement is out of keeping with the quasi-contractual nature of conditional grants.
- The enforcement of standards has been selective, uneven, and political, and has stymied innovation in health care reform.
- Provinces enjoy a comparative institutional advantage over the federal government in contextualizing the meaning of national standards in light of each province's needs and capacities.
- Federal enforcement has lost legitimacy following reductions to transfers in the early 1990s, which have arguably made it more difficult for provinces to satisfy national standards.

Whatever the merit of the arguments, most observers would agree that the unilateral reduction of federal transfers in 1995 poisoned the well of federal-provincial goodwill that is required to ensure the successful governance of Medicare. In our view, breaking the present impasse requires (a) reconceptualizing national standards, and (b) redesigning the institutions that oversee them. In brief, we propose that:

- with respect to the criteria of accessibility and comprehensiveness, and the suggested criterion of public governance and accountability, the emphasis be on encouraging provinces to establish transparent and democratic processes to specify provincial goals for these criteria, rather than laying down a common standard for all of Canada;
- the establishment of a national Medicare Commission, the members of which would be appointed by the provincial and federal governments, with the mandate of providing both intellectual capital and federal financial support for provincial initiatives to redesign health care delivery that have the goal of better meeting the criteria of the CHA; and

- the establishment of a permanent and publicly transparent procedure to settle disputes (including citizen complaints) over the interpretation of national standards in the CHA under the Social Union Framework Agreement.

2. Provincial Processes to Specify Accessibility, Comprehensiveness, and Public Administration

Although the CHA provides for a single set of national standards that all provincial health insurance plans must satisfy, the reality on the provincial ground is different. There is variation across provinces in the extent to which services are accessible, and to a lesser but growing extent, in the range of services that provincial health insurance plans cover. Inter-provincial variation reflects, in part, the fact that the criteria of comprehensiveness and accessibility are open-ended and have not been specified either by the federal government or the courts. The decision not to mandate a specific set of services or standards for accessibility in the CHA reflects the reality that provinces have access to better information regarding the health care needs and institutional capacities of their own systems, and that these needs and capacities differ from province to province.

However, this rationale for federal deference to the provinces still requires provinces to grapple with the national standards of comprehensiveness and accessibility. The fact that national standards can be satisfied by a variety of means (or provincial health insurance plans), should not render the standards devoid of content. Rather, the emphasis should be on the provinces establishing democratic processes to specify provincial goals for these criteria. The federal government could ask the provincial governments to demonstrate the *processes* they have in place to specify and comply with these five criteria – in particular, the criteria of comprehensiveness and accessibility, and the suggested criterion of public governance and accountability – on an annual basis.

The CHA should be amended to require provincial governments to engage their respective citizens in processes to fulfill the five criteria. This is the best way to ensure that the criteria are viewed by the provinces and by the citizens of Canada as fair and the best way to give them substantive content. This kind of provincial undertaking could spark an important public debate within each province over what citizens can reasonably expect of their health care systems (Daniels 2000). In this way, one of the democratic benefits of a federal system – the potential for meaningful citizen participation through decentralized decision making – is realized.

Reconceptualizing national standards as we propose would have many benefits. It would shift the focus of federal-provincial relations away from disputes over enforcement toward a partnership between governments. It would recognize that the application of the five criteria of the CHA might lead to different results in different communities. The latter, of course, might be viewed as a disadvantage, as it could lead to an increase in interprovincial variation. This variation would undermine the "citizenship" rationale of national standards. However, as discussed above, this variability could also be a strength, as a one-size-fits-all approach is appropriate to the goals the system should strive for but not the various means of achieving those goals.

3. Medicare Commission

A second component of reforming the structure of federal-provincial relations in Medicare concerns the institutions that govern it (Choudhry 2000). At present, to the extent that we can speak of a national Medicare system, it is governed exclusively by the federal or provincial governments. As a consequence, Medicare has fallen prey to politics and has become one of the principal arenas for federal-provincial conflict. To be sure, it would be both impossible and undesirable, from the point of view of democratic accountability, for elected governments to extricate themselves from the business of governing Medicare. However, there is a real need for a non-partisan national body, protected from day-to-day politics, and with a longer-term view than is possible for elected government. This national body should ensure that additional federal funding in health care is used to promote reform in accordance with the five criteria of the CHA.

What we propose is the creation of a Medicare Commission. The Commission would be an expert, independent body. Its members would be appointed by provincial and federal governments and its funding secured from the federal government. We address the function, funding, and membership of this body in turn.

Function: The role of this Medicare Commission would be:

- to determine specific performance indicators to help provinces achieve the national standards set out in the CHA. For example, the Commission might issue performance metrics for "reasonable access" that are tailored to particular contexts of treatment (e.g., specialist services, primary care, emergency services);

- to publish (in conjunction with the Canadian Institute for Health Information) annual reports on the performance of provincial health insurance systems according to these performance indicators and how provinces are measuring up to their own identified goals;

- to identify programs that constitutes "best practices," by drawing on both research and experiences in Canada and abroad. If followed, these practices would yield improvements according to standard performance indicators (e.g., best practice standards in primary care and best practice models in primary care reform);

- to provide financial assistance to those provinces that undertake to implement the processes or programs identified by the Commission; and

- to work with provinces to establish processes to better satisfy the criteria of public governance and democratic accountability, accessibility, and comprehensiveness (e.g., processes that best incorporate technical evidence and public values in determining which hospital and physicians services should be publicly funded).

Funding: The Commission's funding would have to be stable and guaranteed. There would have to be a fixed percentage of funding for health care, inflation, and population, adjusted each year. The funding would be separate from federal transfers for health care and would consist, instead,

of new federal money that would pull together all one-off payment initiatives the federal government has currently undertaken in primary care and other areas. **To ensure its legitimacy and credibility, it is crucial that the Commission receive a significant sum of federal funds.**

Membership and Terms of Office: The Commission would have to have both expertise and independence, the latter being achieved through security of tenure and financial security. To ensure that the provincial governments recognize the legitimacy of the Commission, the Commission would need to be appointed jointly by the provincial and federal governments. One possible method of composition would be for each province to appoint one commissioner and the federal government to appoint five, for a total of fifteen. Commissioners would serve full time. They could not be federal or provincial civil servants, consult independently or hold private sector employment. Moreover, to be effective, the Commission must be non-partisan and, to the extent possible, non-politicized. The commissioners would select a chief commissioner from among them. All decisions would require a two-thirds majority, meaning that federal commissioners would require support from a majority of provincial commissioners for any decision. An expert staff of health service researchers would assist the Commission. Finally, the Commission would make its reports publicly available, including specific findings on the compliance of provincial health care plans with national standards.

4. Procedures for Settling Disputes

Disputes will, unfortunately, continue to arise over provincial compliance with the CHA, although, we would argue, with less frequency and with less bitterness should the reforms we propose be implemented. Nonetheless, we think it important to establish procedures under the Social Union Framework Agreement (SUFA) for settling disputes (Choudhry 2000). The need for procedures was evident during the dispute over Alberta's Bill 11, which ultimately turned on competing interpretations of the CHA. The need for procedures has become all the more pressing given the stated desire of some provinces to experiment with public-private partnerships and to delist services that are currently insured.

Article 6 of SUFA establishes a general framework for creating procedures to settle disputes. Within this framework, negotiations should be premised on joint fact-finding, which may be conducted by a third party and would be made public if one party so requests. In addition, negotiations may be accompanied by mediation; again, mediation reports would be made public if one party so requests. Also according to SUFA, mechanisms for dispute resolution must respect a list of general principles. They must be "simple, timely, efficient, effective and transparent;" allow for the possibility of non-adversarial solutions; be appropriate for the specific sectors in which the disputes arise; and provide for the expert assistance of third parties.

The federal and provincial ministers of health on 24 April 2001 announced the establishment of a dispute settlement mechanism for disagreements regarding the interpretation of the CHA. The full details of the proposal have not been released to the public. A Government of Alberta News Release explains that if the federal government and a provincial government are in a dispute over the interpretation of the CHA, then either party may refer the matter to a third-party panel. "The panel will be composed of one representative appointed by the federal government,

one representative appointed by the province or territory and a chairperson agreed to by each government. It will have the ability to provide non-binding advice and recommendations. To ensure an open process, the panel's final report will be made public" (Government of Alberta News Release).

This initiative on the part of the federal and provincial governments is an important step toward facilitating good governance of Medicare. Our reservations are that it is not clear from this proposal whether or not the panels that are constituted will be permanent or *ad hoc*. We think the creation of one permanent national panel is by far the best way to build up expertise and consistency regarding interpretation of the CHA. We also would argue that citizens should be able to invoke the process, as federal and provincial governments may lack the incentive to enforce the law.[9] If a Medicare Commission were created, the regime for settling disputes could be tied to the Commission's work. For example, the Commission might produce fact-finding reports that could serve as the basis for mediations or negotiations and be introduced as evidence in hearings. Finally, we would note that *any* dispute resolution mechanism will remain a hollow protection unless and until the federal government takes a stronger role in enforcing the criteria of the CHA.

V. Expanding the Envelope of Publicly Insured Services

1. Overview

As discussed earlier, there is a need for the creation of national insurance programs for pharmacare and home care, with national standards. These standards need not, however, be the same criteria or standards as those presently in the CHA. In particular, it may be appropriate to levy user charges on people who can afford to pay for certain aspects of home care that bridge the divide between medical and social services (housekeeping services, for example). The prospect of user charges and extra-billing for these services does not raise concerns of the magnitude as are raised in the case of medically necessary physician and hospital services. There is also not the same level of concern about human resources (particularly physicians' labour) being siphoned off by patients willing to pay amounts above and beyond those covered by public health insurance. Moreover, some provinces may wish to follow Quebec's model of managed care in providing for provincial drug plans that cover all citizens and regulate the operation of private insurers as opposed to nationalizing the insurance function. In the eyes of some, this may be seen to be in breach of the public administration criterion as presently configured. Thus, in our opinion, it would be appropriate to provide for national standards for pharmacare and home care by way of separate legislation.

Under our proposal, the federal government would have two policy instruments available to create and implement national standards for prescription drugs and home care:

1. A new federal-provincial shared-cost statute (the "Canada Pharmacare and Home Care Act");

2. Federally created and administered prescription drugs and home care programs (via the federal Crown's contracting power).

2. A Federal-Provincial Shared-Cost Statute

The most obvious solution is to create a new shared-cost statute whereby the federal government would make transfers to the provincial governments in exchange for upholding certain national standards for insuring prescription drugs and home care programs. Because these programs would be created through separate legislation, there would be no need to amend the CHA. The funding arrangements for this new shared-cost statute would be identical to those under the CHA – block funding – and could be incorporated into the new "Canada Health Transfer" that we propose above. The national standards of public administration, comprehensiveness, universality, portability, and accessibility would also still apply, subject to the clarifications and changes discussed earlier. However, we do not think the specific bans on extra-billing and user fees should be included in this new act; at least in the short term. The legislation would, however, have to specify, at a minimum, national standards regarding the income level below which user charges are unacceptable (that takes into account interprovincial variations in the cost of living). Ideally we think it should also provide that care which if not provided in the home or community would result in the patient being hospitalized be provided free of any user charge.

There are disadvantages to this option. First, it would require a significant new federal funding commitment. Second, given the experience surrounding the introduction of the CHST, provinces may be reluctant to launch new public programs without a long-term funding commitment from the federal government or increases in federal cash transfers for CHA-covered programs. Even if the federal government were willing to make such commitments, short of constitutional amendment, a federal government with a majority in Parliament is always free to alter the level of its financial contributions. This option would become more attractive, though, if combined with both the proposals for a Medicare Commission and procedures for settling disputes. Those institutions would restrict federal power (albeit not with respect to levels of funding) and could be viewed accordingly as a *quid pro quo* for new provincial responsibilities.

3. Direct Federal Pharmacare and Home Care Programs

If the federal government possesses the resources but the provinces are unwilling to enter into new shared-cost arrangements for insuring pharmacare and home care, a second option would be for the federal government to create and administer such programs directly. For example, the provinces may be willing to hand over responsibility for the prescription drug budget, given the increasing proportion of total health care costs absorbed by drugs (Canadian Institute for Health Information, 2001). For this very reason, however, the federal government may also be reluctant to take on board such a program, as it would require a significant new funding commitment.

Should direct federal programs be politically viable, the next question is the legal means by which such programs could be created? While the text of the Constitution is silent on jurisdiction over social insurance, the courts have stated that publicly operated insurance schemes that seek to safeguard persons against the risk of illness lie outside federal jurisdiction. Consequently, direct federal regulation of health insurance has been thought to be unconstitutional. This line of analysis seems to preclude the creation of federal insurance programs for prescription drugs and home care without making a constitutional amendment similar to the one that transferred jurisdiction over employment insurance from the provinces to the federal government in 1951. It is exceedingly unlikely that the Constitution could be reopened for such a narrow amendment, given the broad range of unresolved issues the federation already faces and the rise of "mega-constitutional" politics during the Canada Round in the early 1990s.

There is reason, however, to question the thinking behind this premise. A good constitutional argument can be made that Parliament holds the right to legislate health insurance as part of its jurisdiction over the peace, order, and good government of Canada (Choudhry 2002; contra see Jackman 1996, p. 6; 2000). In the current political climate, however, such a frontal challenge to provincial jurisdiction would exact enormous political costs, and its constitutionality would likely be challenged in the courts.

An alternative would be for the federal government to use its contractual power (Choudhry 2002). This power is not mentioned by name in the Constitution. Its source is the common law rule that the Crown (including the federal Crown) possesses all the powers and privileges of a

private individual. Like a private person, the Crown can enter into contracts and, under those contracts, acquire and dispose of its property, including its money. The federal Crown can enter into contracts with individuals or institutions such as corporations or hospitals. Those contracts may contain terms that provide for federal payments to the contracting party in exchange for compliance with certain conditions. When exercising this power, the federal Crown is not constrained by the division of powers. This means that it can enter into contracts in areas outside of federal jurisdiction. Moreover, Parliament has the jurisdiction to legislate with respect to contracts made by the federal Crown, such as laying down the conditions that attach to those payments.

Contracting power has considerable advantages over its spending power (the federal Crown's central policy instrument in health care). The principal limitation of spending power is that conditions are *not* legally enforceable against the recipient in court. The federal Crown's only remedy for non-compliance is to withhold funds. In contrast, once entered into, contracts are legally binding and enforceable in court. However, contracts share one major limitation of conditional grants – unlike legislation, contracts cannot impose legal obligations without the agreement of both contracting parties.

Although federal housing policy through the Canada Mortgage and Housing Corporation uses contracts, federal health policy does not, but it could. The federal government's contractual jurisdiction could be used in a variety of ways. We sketch out here, in rudimentary fashion, two examples involving pharmaceuticals. The details of any such initiatives would obviously need to be more fully fleshed out than is possible here.

In the first case, the federal government could set itself up as a provider of pharmaceutical insurance, operating in a manner nearly identical to that of a private insurer. A private pharmaceutical insurer enters into contracts to regulate its relationships with a variety of parties – beneficiaries (who pay premiums in exchange for receiving coverage) and providers such as pharmacies (who agree to provide pharmaceuticals for a fee set out in a schedule and bill insurance companies directly). If it wished to do so, the federal Crown could enter into a similar set of contractual relationships with beneficiaries and providers. If its terms of coverage were sufficiently attractive, the federal drug plan could coexist or compete with private plans and replace them in the marketplace. As a variation, the federal Crown could contract directly with pharmaceutical companies over its fee schedule, using its purchasing power to contain costs.

In the second case, the federal government could facilitate not only access to prescription drugs but also cost-effective prescribing by physicians. The central contractual relationship would be between the federal Crown and group practices of primary care physicians. The contracts would provide for a fixed, per capita payment to the group practice (altered for case-mix). In exchange, the group practice would agree to manage this budget and pay for pharmaceuticals out of it. Because it would be at risk for pharmaceutical expenditures, the group practice would have the incentive to contain costs.

4. Conclusion

The two options on the table for expanding program coverage – a new shared-cost statute or the creation of federally governed programs – each have advantages and disadvantages from the vantage points of federal-provincial relations and democratic accountability. At this point in time, we would recommend the former option – a new shared-cost statute, modeled on the CHA, but with modifications regarding extra-billing and user fees – as part of the overall package of proposals outlined in this paper. Provinces would more likely accept this package if it adhered to the shared-cost model in the CHA and did not introduce direct federal programs into the mix.

VI. Summary of Recommendations

Three goals drive our recommendations: first, how to modernize the criteria of the CHA and expand its scope to better reflect the needs of contemporary society; second, how to give content to the criteria in the Act, cast as they are in very general terms; and, finally, how to overhaul federal-provincial relations in the health care sector.

A. Modernizing the Criteria: With regard to the five criteria, we recommend the following:

Universality: The criterion of universality is a fundamental principle and should be maintained for hospital and physician services and expanded specifically into diagnostic services. Through separate legislation there should also be universal coverage for prescription drugs and home care. The criterion of universality does not necessitate funding from general tax revenues but, rather, that funding is progressive (i.e., based on ability to pay). New national programs for home care and prescription drugs could be funded, for example, by compulsory social insurance.

Portability: Out-of-country coverage is not core to Medicare. The criterion of portability should be amended so that provinces are not in breach of the CHA if they do not pay for out-of-country treatment.

Public Administration: The criterion of public administration should be recast as "public governance and democratic accountability" to emphasize the importance of good governance and accountability of decision makers at all levels in Medicare. The federal government should monitor the growth of health care delivery by for-profit firms but acknowledge that the CHA does not preclude their participation, *provided services are fully publicly funded.*

Comprehensiveness: The CHA should require provinces to establish transparent and democratic *processes* to determine on an ongoing basis which services and goods should or should not be publicly funded. It should also require that provinces give priority to publicly funding services of proven effectiveness. As well, the scope of services protected by the CHA should be expanded to include all medically necessary diagnostic services (e.g., MRIs). Consideration should be given to requiring provinces to integrate funding for *all* publicly funded health care services (whether protected by the CHA or not) and held by the appropriate level of decision maker.

Accessibility: If Medicare does not respond to Canadians' concerns regarding timeliness of treatment, support for it will be undermined and pressure for privately financed options will increase. The criterion of accessibility in the CHA should be changed to read "reasonable access in a reasonable time frame, given the nature of the health need," in order to incorporate a guarantee of timely access. The CHA should require the provinces to account for the processes they have in place to ensure that all residents of the province have reasonable access to health care goods and services in a reasonable time frame.

B. Extra-billing and User Charges: To prevent the emergence of two-tier health care and queue jumping, the prohibition on extra-billing should remain in place. Extra-billing would allow wealthier Canadians to queue-jump. There is no evidence from any country that allowing extra-billing will reduce waiting lists in public hospitals. On the contrary, countries like New Zealand and the United Kingdom that allow extra-billing and queue jumping have longer waiting lists and times in their public hospitals. Evidence shows that user charges for hospital and physician services may deter both unnecessary and necessary use of care. Thus the prohibition on user charges should remain in place unless a province could establish that a proposed regime of user charges would not deter Canadians from seeking the care they need but only unnecessary care.

The CHA appropriately prevents experimentation with private financing through the prohibitions on user charges and extra-billing *but neither impedes nor encourages* reform or innovation in the *delivery* of health care. We think the CHA should be reformed to actively encourage innovation and evidence-based reform in the delivery of care.

C. Processes for Giving Content to the Criteria of the Act: Currently, the five criteria in the CHA are statements of the values that Canadians want to see reflected in provincial insurance systems across the country. There is, however, no substantive definition provided for crucial phrases such as "medically necessary" and "reasonable access." This is understandable, given that these kinds of requirements must vary over time and between provinces. To give real content to the values articulated in the CHA, the CHA should require provinces to demonstrate the *processes* they have in place to define and comply with the criteria on an annual basis. We believe that this approach would shift the focus of federal-provincial relations away from disputes over enforcement and pervasive acrimony toward a partnership between the federal and provincial governments. By shifting toward a system that focuses primarily on accountability for processes, we recognize that a one-size-fits-all approach is appropriate to the *values* the system strives for but not the various *means* of realizing those values.

D. Overhauling Federal-Provincial Relations in Health Care: Federal-provincial relations in health care are in desperate need of repair. To this end, Medicare requires the creation of two sets of joint federal-provincial institutions to govern it. First, we propose the establishment of a jointly appointed, non-partisan and expert Medicare Commission to work with the provinces to establish processes to better satisfy the criteria of comprehensiveness, accessibility, and public governance and accountability. The Commission would reward provinces that meet objective performance indicators or that implement those reforms the Commission identifies as worthwhile. To effect real change in the system, the Commission would have to receive a significant sum of federal funds above and beyond existing transfer payments. Second, we propose the creation of permanent procedures under the Social Union Framework Agreement to deal with disputes over the interpretation of the CHA. Disputes would be heard by specialist panels. Moreover, in addition to being triggered by government complaints, the machinery could also be invoked directly by citizens.

E. National Programs for Prescription Drugs and Home Care: Separate legislation is required to provide for national standards for insuring prescription drugs and home care. This legislation will likely have to take the form of a new shared-cost statute similar to the CHA, but with national standards for access rather than an outright prohibition on user charges. We believe that

some user charges may be appropriate in a national home care system as home care straddles the medical care and social services sector, e.g., homemaking services may appropriately attract a user fee. In the case of prescription drugs, it is vital that Canadians not be deterred from obtaining necessary prescription drugs because of fees. But, for example, the imposition of a user charge upon a brand name drug as opposed to a generic drug would seem acceptable.

VII. Conclusion

The *Canada Health Act* has served Canadians extremely well since 1984. However, to continue to realize the values that lie behind the Act, some changes are necessary. Instead of regarding the CHA as a quasi-constitutional document that should be altered with great reluctance, the statute should be regarded as a delivery vehicle for public health care policy that from time to time must be adapted to changing circumstances. In other words, the Act is a means, not an end in itself. At this critical juncture, to view it in any other way would be dangerous because it would make the CHA an obstacle to necessary change in the structure and governance of Medicare as opposed to a facilitator of those changes. Underlying and uniting the specific reforms we propose, is a broader call for dramatic change in the mindset that governs the legal and governance framework for Medicare. For Medicare to survive into the 21st century, it must be both effective and legitimate. And to be both of these things, it must be flexible and adaptable. Canadians deserve no less.

Notes

1 R.S.C. 1985, c. C-6 [hereinafter "*CHA*"].

2 "Extended health care services" are defined as nursing home intermediate care, adult residential care, home care, and ambulatory health care services. To obtain a federal contribution for extended health care services, the provinces need only comply with section 13. This section requires provinces to provide information to the federal government and formally recognize the latter's contributions in promotional material and public documents.

3 Thus, for example, the Australian government has reciprocal agreements with eight countries: the United Kingdom, New Zealand, Finland, Italy, Ireland, Malta, the Netherlands and Sweden. In these countries, Australians are provided with urgent or emergency medical treatment. See http://www.hic.gov.au/yourhealth/services_for_travellers/tofa.htm.

4 We are grateful to Carolyn Tuohy for this point.

5 Any process to decide which services to include is a complex one that must incorporate societal values in achieving different kinds of health states, technical evidence about the efficacy of different means of achieving these states, and economic evidence of the cost of those, given the value as a society we put on achieving different health care outcomes and responding to different needs.

6 In 2000, provincially appointed committees in Quebec (the Clair Commission) and Saskatchewan (the Fyke Commission) reported, both calling for primary care reform (see Quebec, Ministry of Health, Commission on Medicare. 2001. Emerging Solutions: Report and Recommendations. Quebec: Commission on Medicare, available at http://www.cessss.gouv.qc.ca/pdf/en/01-109-01a.pdf); Saskatchewan, Department of Health, The Commission on Medicare. 2001. Caring for Medicare: Sustaining a Quality System. Regina: Commission on Medicare, available at http://www.legassembly.sk.ca/hcc). In 2001, a provincially-appointed committee in Alberta (the Mazankowski Commission) required a raft of controversial reforms, but included among these reforms is yet a further call for primary care reform – see on-line: http://www.premiersadvisory.com.

7 Thus any province that imposed user charges should prohibit private insurance coverage if the goal is truly to control total health care costs and utilization. This is what Australia does for physician services.

8 There have been several initiatives designed to meet the need for security in terms of the amount of federal funding. In 1996, following the recommendations of the National Forum on Health, the federal government further amended the *Federal-Provincial Fiscal Arrangements Act* to provide a floor of $11 billion per year for the cash component of the CHST, and in 1997-98, this floor was increased to $12.5 billion.

9 To guard against frivolous and vexatious complaints, and ensure that novel issues reach panels, a screening body such as a permanent secretariat would need to investigate complaints. It is also important to ensure that this process would not be captured by health care providers and used as a means to resolve disputes over compensation and working conditions.

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